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DEPARTMENT OF PREVENTIVE MEDICINE AND BIOMETRICS

PMO 526
HEALTH SERVICES ADMINISTRATION

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The American public has modified its expectations of healthcare professionals in the past 25 years, and the attractions to healthcare as a profession are different than in 1960. Describe the major changes in health professions as a result of these factors and explain how changes in the healthcare delivery system have affected these professions.

09/20/2002

The American health care system has undergone major changes in its organization, financing mechanisms, and delivery activity during the past two decades to meet the needs and demands of the population. This discussion focused on a variety of changes within the current health care system including: 1) the rapid growth of the numbers of different types of professions; 2) technological advances and clinical specialization; 3) healthcare delivery, including role expansion within existing health care professions; 4) public perceptions concerning delivery of services; and 5) relative attractiveness to the health professions.

One recent change is the increased numbers of physicians, nurses, pharmacists, and other health personnel such as Physicians Assistants (PAs) and Nurse Practitioners (NPs). Reasons for the increased supply and wide variety of health care personnel include a perceived national shortage of medical doctors, technological growth, specialization, and new competing environments. Technological innovation has led to increased specialization of health care personnel and the emergence of new allied health professions. However, technology and increased emphasis on quality and specialization have created problems with distribution and numbers of health care professionals, which is a growing concern as the U.S. population ages.

Advanced technology has significantly improved diagnostic and treatment procedures leading to increased utilization of financially solvent urban hospitals that are able to purchase expensive medical equipment. This concentration of technologically sophisticated equipment is resulting in a corresponding concentration of highly skilled health personnel in urban areas. Some health care personnel have been unwilling to locate in rural areas because of inadequate or outdated medical facilities, professional

isolation, limited support services, and inadequate organizational settings (e.g., fewer opportunities to participate in group practice). In addition, health care personnel in underserved areas experience excessive workload and time demands, limits on earnings, and lack of social, cultural, and educational opportunities. Although federal and state efforts such as funding and establishment of laws are altering the urban/rural location of some health personnel, unequal distribution persists.

William and Torrens noted that there are remarkable differences in health care delivery between geographic locations, particularly in economically disadvantaged and rural areas, although health care provider supply appears to be adequate. It was suggested that allowing International Medical Graduates (IMGs) into the health care workforce has filled some of the perceived provider gaps. The IMGs are frequently practicing in specialties, geographic locations, and employment settings avoided by U.S. medical graduates. With increasing market penetration, managed care plans have also facilitated this increase by employing more IMG's.

Recently, a growing proportion of registered nurses have entered the workforce from associate degree programs. This may facilitate bachelor degree qualified nurses to move out of direct patient care roles into supervisory or administrative positions. This further exacerbates the mal-distribution of resources in that rural and inner city hospitals cannot offer an adequate range of incentives (e.g., flexible working hours, increased salaries, and safe working conditions) to attract highly qualified nurses.

The physician-nurse relationship also has promoted role-expansion in the nursing profession within the context of clinical decision-making in the hospital. With the increased education and specialization attained by nurses, they are unwilling to fulfill the

traditional responsibilities of the stereotypical nurse, an underpaid female hospital laborer. They are assuming an independent role and increasing their direct responsibility in comprehensive care within institutional settings. This trend is creating new professional roles outside traditional nursing boundaries, especially for public health nurses.

Similar to the changes in the nursing profession, the U.S. has seen a steady growth in the number of pharmacists. Pharmacy professionals are expanding their roles from merely filling prescriptions, preparing drug products, and other traditional routine activities to include more clinical responsibilities such as providing consultation and monitoring, and evaluating drug regimens with their clients, as well as other members of the clinical medical team. With their continually expanding roles, the amount of time an individual pharmacist might spend performing traditional activities is projected to decline. Pharmacy technicians also are assuming a more active role, in addition to performance of traditional retail pharmaceutical practices.

The perceptions of how the American public views health care is dramatically different than it was in the 1960s. During the 1960s, the prevalent perception was that men were expected to be the physicians and women were more typically employed as nurses. Recently, with a significant growth of women in all of the health professions, this perspective has shifted into a balance of almost 50/50 male and female. Moreover, patients today are more informed and educated, and are taking an active role in their medical care (e.g., questioning the physician's reasons for specific treatment and/or procedures). Also, they are discovering that other types of professionals represent reliable sources of health care information, in addition to their physicians. As such,

physicians need to be increasingly more specialized and knowledgeable. Post-graduate medical education has become essential training that physicians must attain to continue to be viable in this highly competitive profession. This has accounted for higher percentages of filled residency positions and a resultant cheaper labor force at large, usually urban teaching hospitals.

The readings indicated that there was a shift in public perception from an oversupply of physicians to a perceived shortage of physicians. This created increased funding for teaching hospitals, and increased numbers of both U.S. and foreign residents. These forces also may be acting in conjunction with the two types of health care providers: PAs and NPs who are taking on more primary care responsibilities, in order to the fill gaps in the health care system.

Another issue is the current public attraction to the health care professions. Fewer numbers of individuals are entering the health professions today, further exacerbating the shortage of care available to populations that may be already underserved. Some argued that physicians should be paid according to their level of expertise, training, and education, regardless of where they are geographically located. In practice, this is a very difficult undertaking. However, possible solutions include development of policies to alter physician distribution, and the creation of a reimbursement system that provides financial incentives for physicians to practice in underserved areas.

Related to the difficulty associated with attraction to the health care field is the declining number of applications to medical schools. This may be partially related to the decreased prestige associated with the profession, but also may reflect the increasing costs of medical training in a managed care environment. Downsizing of many medical

schools is also due to managed care cost-cutting measures, and the secondary and tertiary effects of decreased salary, autonomy, and the ever-increasing costs of attaining a medical education.

In the discussion, it was noted that people want and expect only the best in technology and specialization at an affordable price. Individuals also want caring and compassionate old-fashioned care. Often the forces that have shaped medicine have made these two expectations contradictory. It is, therefore, essential that the make-up of the health care workforce be monitored closely, as the decisions that are made today must be applicable and executable in the future, as the "face" of the American public changes over time.

In conclusion, the U.S. health care system has realized significant growth and change in the composition of the health care workforce over the last 40 years. This growth has created attractive, yet competing environments where health care providers must act as efficiently as possible to provide services. Continued emergence of new allied health professions, evolving trends in technology, further specialization of workforce personnel as well as role-expansion within existing healthcare professions, healthcare shortages in rural and underserved populations and an overall aging population, combined with the public's perception of healthcare delivery and attractiveness to the healthcare professions are all critical factors that must be considered in managing the evolving system of American health care.